



MEMBERSHIP APPLICATION

INDIVIDUAL			
first name			
last name			
degree/designation			
professional title			
organization			
mailing address			
city	state	zip	
phone	fax		
email			
website			
service description	<p>Describe the activities or role that you or your organization provide in the field of complex disorders, mental health/substance use disorder treatment, recovery, prevention, advocacy, or other related fields.</p> <p><i>Please attach separately. Include any brochures, flyers, or other materials that describe your services.</i></p>		
annual fee	\$25	<input type="checkbox"/> payment enclosed	

Individual Member Benefits

- Discounted training programs
- Free access to static online courses
- Annual meeting showcasing collaborative and member activities
- Guidance and support for best practices
- Networking opportunities
- Cross-promotion

Individual Member Requirements

All applications will be reviewed by the CCSME Board of Directors prior to approval.

- A membership application must be completed in full and submitted to CCSME
- The individual must be in good standing in the community
- A signature is required



MEMBERSHIP AGREEMENT

FOR PERIOD: 2014–2017

CCSME Mission

The Co-Occurring Collaborative Serving Maine advocates for best practices, encourages professional development, maximizes collaboration, and facilitates integrated health and behavioral health services.

Terms & Dues

The terms of this agreement are in effect throughout the period shown above, and will be reviewed at the end of that period. Dues for membership are invoiced annually.

Agreement

As a member of CCSME, _____
Name of Organization / Individual / Student

agrees to support the mission of the Co-Occurring Collaborative Serving Maine (pending board approval of membership application).

Guidelines

Member organizations/individuals/students will:

- Subscribe to CCSME's mission.
- Exchange information, share resources, and participate in activities to improve services for persons and their families with complex mental health, substance use, and/or other health issues.
- Participate, as able, in CCSME's annual membership meeting.

Name of Organization / Individual / Student, Title if applicable (please print)

Point of Contact for Organization / Company Name for Individual (if applicable) / Educational Institution for Student

Signature (*Organization agreement must be signed by an authorized signatory*) Date

Return signed agreement to:

94 Auburn Street, Suite 110 | Portland, Maine 04103
Tel: 207-878-6170 | Fax: 207-878-6172
ccsme@ccsme.org | www.ccsme.org